Analysis – Montana PCMH Law and NCQA Patient-Centered Medical Recognition May 2013

Montana Patient-Centered Medical Home Law	NCQA Patient-Centered Medical Home Recognition Standards
Section 4 – Definition of PCMH, Subsection a) directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems	**[Abbreviated] Definition of Eligibility for PCMH: The Patient Centered Medical Home (PCMH) 2011 program is for practices that provide first contact, continuous, comprehensive, whole person care for patients across the practice. Whole person care includes provision of comprehensive care and self management support and emphasizes the spectrum of care needs, such as routine and urgent care; mental health; advice, assistance and support for making changes in health habits and making health care decisions. Preventive care is also a key component of the expectation for clinician focus.** **PMCH 1D: Continuity** **The practice provides continuity of care for patients/families by:** **1. Expecting patients/families to select a personal clinician** **2. Documenting the patient's/family's choice of clinician** **3. Monitoring the percentage of patient visits with selected clinician or team.** **PCMH 1E: Medical Home Responsibilities** **The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following.** **1. The practice is responsible for coordinating patient care across multiple settings** **2. Instructions on obtaining care and clinical advice during office hours and when the office is closed** **3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice** **4. The care team provides the patient/family with access to evidence-based care and self-management support** **PCMH 1F: Culturally and Linguistically Appropriate Services**

	The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: **1. Assessing the racial and ethnic diversity of its population** **2. Assessing the language needs of its population** **3. Providing interpretation or bilingual services to meet the language needs of its population** **4. Providing printed materials in the languages of its population**
Section 4 – Definition of PCMH, Subsection b) characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and satisfaction	**PCMH 1A: Access During Office Hours** **The practice has a written process and defined standards, and** **demonstrates that it monitors performance against the standards for:** **1. Providing same-day appointments** **2. Providing timely clinical advice by telephone during office hours** **3. Providing timely clinical advice by secure electronic messages during office hours** **4. Documenting clinical advice in the patient medical record.** **PCMH 1B: After-Hours Access** **The practice has a written process and defined standards and demonstrates that it monitors performance against the standards for:** **1. Providing access to routine and urgent-care appointments outside regular business hours** **2. Providing continuity of medical record information for care and advice when office is not open** **3. Providing timely clinical advice by telephone when the office is not open** **4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open** **5. Documenting after-hours clinical advice in patient records** **PCMH 1C: Electronic Access** **The practice provides the following information and services to patients and families through a secure electronic system.** **1. More than 50 percent of patients who request an electronic copy** **of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists**

	and allergies) receive it within three business days+ **2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice** **3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days** **4. Two-way communication between patients/families and the practice** **5. Request for appointments or prescription refills** **6. Request for referrals or test results.** **PCMH 2D: Use Data for Population Management** **The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:** **1. At least three different preventive care services** **2. At least three different chronic or acute care services** **3. Patients not recently seen by the practice** **4. Specific medications** **PCMH 3A: Implement Evidence-based Guidelines** **The practice implements evidence-based guidelines through point of care reminders for patients with:** **1. The first important condition** **2. The second important condition** **3. The third condition, related to unhealthy behaviors or mental health or substance abuse** **PCMH 6A: Measure Performance** **The practice measures or receives data on the following:** **1. At least three preventive care measures** **2. At least three chronic or acute care clinical measures** **3. At least two utilization measures affecting health care costs** **4. Performance data stratified for vulnerable populations (to assess disparities in care).** **PCMH 6B: Measure Patient/Family Experience**

	The practice obtains feedback from patients/families on their experiences with the practice and their care. **1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:** **• Access** **• Communication** **• Coordination** **• Whole person care/self-management support** **2. The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician & Group Survey Tool** **3. The practice obtains feedback on experiences of vulnerable patient groups** **4. The practice obtains feedback from patients/families through qualitative means.** **PCMH 6C: Demonstrate Continuous Quality Improvement** **The practice demonstrates ongoing monitoring the effectiveness of its improvement process by:** **1. Tracking results over time** **2. Assessing the effect of its actions** **3. Achieving improved performance on one measure** **4. Achieving improved performance on a second measure.** **PCMH 6D: Demonstrate Continuous Quality Improvement** **The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:** **1. Tracking results over time** **2. Assessing the effect of its actions** **3. Achieving improved performance on one measure** **4. Achieving improved performance on a second measure**
Section 4 – Definition of PCMH, Subsection c) qualified by the commissioner under [section 4] as meeting the standards of a patient-centered medical home	**Not applicable**
Section 4 – Definition of PCMH, Subsection d) reimbursed under a payment system that recognizes the value of services that meet the	**There is no specific payment methodology that practices/payers are required to use with NCQA's program. NCQA's program is flexible and has been**

standards of the patient-centered medical home program.	**used alongside different payment models such as quality-based bonuses and per-member per-month care coordination fees.**
Section 5 – Standards for Patient-Centered Medical Homes, Subjection 7) In developing the standards described in section (2), the commissioner may consider: a) the use of health information technology, including electronic medical records.	**NCQA PCMH Recognition is fully aligned with the Medicare and Medicaid EHR Incentive Programs Stage 1 Core and Menu Meaningful Use requirements. Providers that demonstrate compliance with Stage 1 requirements can receive credit on the applicable PCMH standards. NCQA plans to align the PCMH program with Stage 2 Core and Menu requirements in future updates to the program.** **Example: PCMH 3E: Use Electronic Prescribing** **The practice uses an electronic prescription system with the following capabilities.** ***1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies (Meaningful Use Stage 1 Core Requirement)*** **2. Generates at least 75 percent of eligible prescriptions** **3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list+** **4. Performs patient-specific checks for drug-drug and drug-allergy interactions *(Meaningful Use Stage 1 Core Requirement)*** **5. Alerts prescriber to generic alternatives** **6. Alerts prescriber to formulary status *(Meaningful Use Stage 1 Menu Requirement)*** **Please note that NCQA does not require providers to participate in one of the EHR Incentive programs nor required to use ONC-Certified EHR technology to be recognized as a PCMH.**
Section 5 – Standards for Patient-Centered Medical Homes, Subjection 7) In developing the standards described in section (2), the commissioner may consider: **b) the relationship between the primary care practice, specialists, other health care providers and hospitals**	**PCMH 4B: Provide Referrals to Community Resources** **The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following.** **1. The practice is responsible for coordinating patient care across multiple settings** **2. Instructions on obtaining care and clinical advice during office hours and when the office is closed** **3. The practice functions most effectively as a**

	medical home if patients provide a complete medical history and information about care obtained outside of the practice **4. The care team provides the patient/family with access to evidence-based care and self-management support** **PCMH 5B: Referral Tracking and Follow Up** **The practice coordinates referrals by:** **1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information** **2. Tracking the status of the referrals, including required timing for receiving a specialist's report** **3. Following up to obtain specialist's report** **4. Establishing and documenting agreements with specialists in the medical record if co-management is needed** **5. Asking patients/families about self-referrals and requesting reports from clinicians** **6. Demonstrating capacity for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians** **7. Providing an electronic summary of care record to another provider for more than 50 percent of referrals.** **PCMH 5C: Coordinate with Facilities and Care Transitions** **On its own or in conjunction with an external organization, the practice systematically:** **1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit** **2. Demonstrates its process for sharing clinical information with admitting hospitals or emergency departments** **3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities** **4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit** **5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization**

	6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care **7. Demonstrates the ability for electronic exchange of key clinical information with facilities** **8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care.**
Section 5 – Standards for Patient-Centered Medical Homes, Subjection 7) In developing the standards described in section (2), the commissioner may consider: **c) the access standards for individuals covered by a health plan to receive primary medical care in a timely manner**	**PCMH 1A: Access During Office Hours** **The practice has a written process and defined standards, and** **demonstrates that it monitors performance against the standards for:** **1. Providing same-day appointments** **2. Providing timely clinical advice by telephone during office hours** **3. Providing timely clinical advice by secure electronic messages during office hours** **4. Documenting clinical advice in the patient medical record.** **PCMH 1B: After-Hours Access** **The practice has a written process and defined standards and demonstrates that it monitors performance against the standards for:** **1. Providing access to routine and urgent-care appointments outside regular business hours** **2. Providing continuity of medical record information for care and advice when office is not open** **3. Providing timely clinical advice by telephone when the office is not open** **4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open** **5. Documenting after-hours clinical advice in patient records** **PCMH 1C: Electronic Access** **The practice provides the following information and services to patients and families through a secure electronic system.** **1. More than 50 percent of patients who request an electronic copy** **of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within three business days** **2. At least 10 percent of patients have electronic**

	access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice **3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days** **4. Two-way communication between patients/families and the practice** **5. Request for appointments or prescription refills** **6. Request for referrals or test results.**
Section 5 – Standards for Patient-Centered Medical Homes, Subjection 7) In developing the standards described in section (2), the commissioner may consider: **d) the ability of the primary care practice to foster a partnership with patients**	**PMCH 1D: Continuity** **The practice provides continuity of care for patients/families by:** **1. Expecting patients/families to select a personal clinician** **2. Documenting the patient's/family's choice of clinician** **3. Monitoring the percentage of patient visits with selected clinician or team.** **PCMH 1E: Medical Home Responsibilities** **The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following.** **1. The practice is responsible for coordinating patient care across multiple settings** **2. Instructions on obtaining care and clinical advice during office hours and when the office is closed** **3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice** **4. The care team provides the patient/family with access to evidence-based care and self-management support** **PCMH 1F: Culturally and Linguistically Appropriate Services** **The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families.** **1. Assessing the racial and ethnic diversity of its population** **2. Assessing the language needs of its population** **3. Providing interpretation or bilingual services to meet the language needs of its population**

	4. Providing printed materials in the languages of its population **PCMH 2C: Comprehensive Health Assessment** **To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes:** **1. Documentation of age- and gender appropriate immunizations and screenings** **2. Family/social/cultural characteristics** **3. Communication needs** **4. Medical history of patient and family** **5. Advance care planning (NA for pediatric practices)** **6. Behaviors affecting health** **7. Patient and family mental health/substance abuse** **8. Developmental screening using a standardized tool (NA for practices with no pediatric patients)** **9. Depression screening for adults and adolescents using a standardized tool.** **PCMH 3C: Care Management** **The care team performs the following for at least 75 percent of the patients identified in Elements A and B.** **1. Conducts pre-visit preparations** **2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit** **3. Gives the patient/family a written plan of care** **4. Assesses and addresses barriers when the patient has not met treatment goals** **5. Gives the patient/family a clinical summary at each relevant visit** **6. Identifies patients/families who might benefit from additional care management support** **7. Follows up with patients/families who have not kept important appointments** **PCMH 4A: Support Self-Care Process** **The practice conducts activities to support patients/families in self-management:** **1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management**

	2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate **3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families** **4. Documents self-management abilities for at least 50 percent of patients/families** **5. Provides self-management tools to record self-care results for at least 50 percent of patients/families** **6. Counsels at least 50 percent of patients/families to adopt healthy behaviors** **PCSP 6B: Measure Patient/Family Experience** **The practice obtains feedback from patients/families on their experiences with the practice and their care.** **1. The practice conducts a survey (using any instrument) to evaluate patient/ family experiences on at least three of the following categories: Access, Communication, Coordination and Whole-person care/self-management support** **2. The practice uses the CAHPS Patient-Centered Medical Home (PCMH) survey tool** **3. The practice obtains feedback on the experiences of vulnerable patient groups** **4. The practice obtains feedback from patients/families through qualitative means.**
Section 5 – Standards for Patient-Centered Medical Homes, Subjection 7) In developing the standards described in section (2), the commissioner may consider: **(e) the use of comprehensive medication management to improve clinical outcomes.**	**PCMH 2B: Clinical Data, Factor 2** **The practice uses an electronic system to record the following as structured (searchable) data.** **2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients** **PCMH 2D: Use Data for Population Management, Factor 4** **The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:** **4. Specific medications.** **PCMH 3D: Medication Management** **The practice manages medications in the following**

	ways. **1. Reviews and reconciles medications with patients/families for more than 50 percent of care transitions** **2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions** **3. Provides information about new prescriptions to more than 80 percent of patients/families** **4. Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment** **5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment** **6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families with the date of updates.** **PCMH 6E: Use Electronic Prescribing** **The practice uses an electronic prescription system with the following capabilities.** **1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies** **2. Generates at least 75 percent of eligible prescriptions** **3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list** **4. Performs patient-specific checks for drug-drug and drug-allergy interactions** **5. Alerts prescribers to generic alternatives** **6. Alerts prescribers to formulary status**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders: a) payment methods used by health plans to pay patient-centered medical homes for services associated with the coordination of covered health care services	**There is no specific payment methodology that practices/payers are required to use with NCQA's program. NCQA's program is flexible and has been used alongside different payment models such as quality-based bonuses and per-member per-month care coordination fees.**

Section 5 – Standards for Patient-Centered Medical Homes, Subsection 2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders: b) bonuses, fee-based incentives, bundled fees, or other incentives that a health plan may use to pay a patient-centered medical home based on the savings from reduced health care expenditures associated with improved health outcomes and care coordination by qualified individuals attributed to the participation in the patient-centered medical homes	**There is no specific payment methodology that practices/payers are required to use with NCQA's program. NCQA's program is flexible and has been used alongside different payment models such as quality-based bonuses and per-member per-month care coordination fees.**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders: c) a uniform set of health care quality and performance measures that include prevention services; and d) a uniform set of measures related to cost and medical usage.	**PCMH 6A: Measure Performance** **The practice measures or receives data on the following:** **1. At least three preventive care measures** **2. At least three chronic or acute care clinical measures** **3. At least two utilization measures affecting health care costs** **4. Performance data stratified for vulnerable populations (to assess disparities in care).** **PCMH 6B: Measure Patient/Family Experience** **The practice obtains feedback from patients/families on their experiences with the practice and their care.** **1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:** **• Access** **• Communication** **• Coordination** **• Whole person care/self-management support** **2. The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician & Group Survey Tool** **3. The practice obtains feedback on experiences of vulnerable patient groups** **4. The practice obtains feedback from patients/families through qualitative means.** **PCMH 6C: Implement Continuous Quality Improvement**

	The practice uses an ongoing quality improvement process to: **1. Set goals and act to improve on at least three measures from Element A** **2. Set goals and act to improve quality on at least one measure from Element B** **3. Set goals and address at least one identified disparity in care/service for vulnerable populations** **4. Involve patients/families in quality improvement teams or on the practice's advisory council.** **PCMH 6D: Demonstrate Continuous Quality Improvement** **The practice demonstrates ongoing monitoring the effectiveness of` its improvement process by:** **1. Tracking results over time** **2. Assessing the effect of its actions** **3. Achieving improved performance on one measure** **4. Achieving improved performance on a second measure** **PCMH 6E: Report Performance** **The practice shares performance data from Element A and Element B:** **1. Within the practice, results by individual clinician** **2. Within the practice, results across the practice** **3. Outside the practice to patients or publicly, results across the practice or by clinician.** **PCMH 6F: Report Data Externally** **The practice electronically reports:** **1. Ambulatory clinical quality measures to CMS** **2. Ambulatory clinical quality measures to other external entities** **3. Data to immunization registries or systems** **4. Syndromic surveillance data to public health agencies.**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 3) A patient-centered medical home must meet the standards in this section in full or in part by providing proof to the commissioner that it has been accredited by a nationally recognized accrediting organization	**Not applicable**

approved by the commission	
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 4) The commissioner may, in consultation with stakeholders, set standards that are specific to Montana and may be required in addition to nationally recognized accreditation standards.	**Not applicable**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 5) A patient-centered medical home shall report on its compliance with the uniform set of health care quality and performance measures adopted by the commissioner to: (a) health plans and other payers with which the patient-centered medical home contracts; (b) the commissioner; and (c) the department, if the department is a participant.	**As noted above, aside from measures in the Electronic Health Record Incentive program NCQA does not ask practices to collect and report on a specific set of clinical quality or cost measures. Practices (and or their payer partners) have flexibility within the domains of prevention, chronic care and utilization to choose the measures most appropriate for their practice or initiative. Depending on the measures chosen by Montana and the use of the data by the practices, they could receive credit for those activities under PCMH 6A-F.**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 6) A health plan and other payers shall report to the patient-centered medical home regarding their compliance with the uniform set of cost and utilization measures adopted by the commissioner for patients covered under the health plan.	**Health plan requirement, not applicable**
Section 5 – Standards for Patient-Centered Medical Homes, Subsection 8) All health care providers and payers who participate in a patient-centered medical home shall, as a condition of participation, collectively commission one independent study on savings generated by the patient-centered medical home program and report to the children, families, health, and human services interim committee no later than September 30, 2016.	**Not applicable**